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ABSTRACT

An important goal of health education is to change behavior by increasing knowledge, but current theory has not been able to account for the actual health behavior of adolescents. Theoretical and empirical work has been focused on explaining individual health behaviors: for example, risky adolescent behaviors such as drinking, smoking, drug use, and unprotected sexual contact. Such models as the Health Belief Model and Fishbein's Theory of Reasoned Action offer explanations of health behaviors. The focus of these models has been to explain the means by which adolescents use cost/benefit analysis to form intentions to act. However, the problem of enactment, or the acting out of intentions, has not been effectively accounted for by current models. The challenge remaining is to translate knowledge about health issues and healthy intentions into healthy behaviors. Programs might augment their success by utilizing an additional focus on enactment skills. Such skills training must center on making it possible to enact health-promoting choice while maintaining self-presentational goals. Thus, researchers should attempt to develop a theory-based approach to the development of a skills curriculum capable of helping to bridge the gap between intention and enactment. (Forty-nine references are attached.) (Author/HB)

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A CHALLENGE FOR HEALTH EDUCATION: THE ENACTMENT PROBLEM AND A COMMUNICATION-RELATED SOLUTION

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A CHALLENGE FOR HEALTH EDUCATION: THE ENACTMENT PROBLEM AND A COMMUNICATION-RELATED SOLUTION

Abstract

Theoretical and empirical work has been focused at explaining and predicting individual health behaviors such as risky adolescent behaviors (drinking, smoking, drug use, unprotected sexual contact). Such models as the Health Belief Model and Fishbien's Theory of Reasoned Action have offered explanations of health behaviors. The focus of these models has been to explain the means by which adolescents use cost/benefit analysis to form intentions to act. The underlying thesis of this paper is that the problem of enactment - the acting out of intentions - has not been effectively accounted for by current models. A challenge remains to translate knowledge about health issues and healthy intentions into healthy behaviors. A logical and useful place to begin will be to approach enactment as a communication problem. This paper, (1) reviews the evidence of the limited success of health education to produce behavior change, (2) explores some factors that explain why knowledge gain may not lead to behavior change, (3) suggests how a communication based curricula can help bridge the gap between knowledge gain and behavior, and (4) sets a research agenda for health communication scholars to study health behavior enactment that will have implications for the practice of health education.

The chief causes of adolescent injury, illness and mortality stem from preventable, social, environmental and behavioral factors (Millstein, 1989). Health education and health communication literature is riddled with alarming statistics pointing to the dangerous behaviors of adolescents today. Zelnik & Kanter (1980) report that the average age at which young women have their first intercourse experience is 16.2 years. Fifty six percent of males are reported to have had intercourse by age 17, and 77 percent by age 19 (Zelnik & Kanter, 1980). Most of first intercourse experiences are unplanned. Only 17% of women and 25% of men reported planning their first intercourse experience (Zelnik & Shah, 1983). It is estimated that, if present trends continue, 40% of today's 14 year old females will be pregnant before they reach the age of 20 (Taylor, Wang, Jack, & Adame, 1989). The number of AIDS cases among adolescents resulting from sexual activity and drug abuse, is doubling every year (Boxer et al., 1989). Injury and death of adolescents is often related to the strong connection between substance abuse and accidents (Millstein, 1989). And even though adolescents may remain healthy during their teen years, the relationship between behaviors initiated during adolescence and health consequences in adulthood is cause for concern (Millstein, 1989; Chassin, Presson & Sherman, 1987).

Theoretical and empirical work has been focused at explaining and predicting individual health behaviors such as the risky adolescent behaviors documented above (Kronenfeld, 1980). Among others, the Health Belief Model and Fishbein's Theory of Reasoned Action have been offered as explanatory frameworks to predict health behaviors. These theories have focused on the relationship of cognitive cost/benefit analyses by individuals and their resulting intention to behave as predictors of actual behavior (Ajzen & Fishbein, 1980; Janz & Becker, 1984; Kronenfeld, 1988). Largely ignored by these accounts of behavior and by the empirical investigations of these models, is the actual enactment of health behaviors. Enactment can be generally defined as the implementation or "acting out" of preferences or choices. For the purposes of this paper, enactment will be defined by three components; (1) physical behavior (e.g., smoking a cigarette, engaging in sexual intercourse), (2) communicative behavior (e.g., statement of preference to use a condom during intercourse, explaining decision not to participate), and (3) social and self identity

management (e.g., managing self-image, managing public-image, managing relationships, defining self and peers). This is not to suggest that these three components are necessarily separable. To the contrary, they are undoubtedly intertwined within any single interaction. While models of health decision making have addressed some of these components as variables determining the formation of intention (Ajzen & Fishbein, 1980), they have not explicitly viewed them as strong moderating variables in linking intention to actual behavior. That is, while attention is paid to these enactment issues as they weigh in a cost/benefit analysis of whether to act, they have not been viewed as problematic in acting out intentions.

The underlying thesis of this paper is that current theory has not been able to account for actual health behavior of adolescents. This is due primarily to the focus on explaining and altering behavioral intentions. A recent call for skills curricula has raised the issue of equipping adolescents to carry out their health-promoting intentions. Health educators have begun to recognize that increasing health-promoting knowledge, enhancing decision-making skills, and encouraging health conscious attitudes among adolescents does not necessarily entail healthy behavior. A challenge still remains to translate intention into behavior change. This paper (1) reviews the evidence of the limited success of health education to produce behavior change, (2) explores some factors which explain why knowledge gain and intention to behave healthily may not lead to behavior change, (3) suggests how a communication based curricula can help bridge the gap between knowledge gain, intention and behavior, and (4) sets a research agenda for the study of health behavior enactment that has implications for the practice of health education.

The domain of this argument is purposefully narrow. *This paper focuses on adolescent enactment of health-risk behaviors which take place in social situations.* Because adolescents experience significantly more self-defining and relationship-defining experiences than do adults and have less developed communication skills, they are at particular risk for the enactment problem. The focus on health-risk behavior, rather that preventive health behavior, addresses some of the most alarming concerns, noted earlier, of adolescent health behavior today and are the behaviors for which enactment is most problematic. The focus on socially enacted health behaviors is an especially important one since it is within the domain of dyadic and group activity

that enactment of health-promotive behaviors becomes problematic. In these situations identity management often becomes paramount and behavioral decisions become "tandem decisions" wherein enactment may necessitate rejection of peer influence.

A Challenge for Health Education

One important goal of health education is to change behavior by increasing knowledge. This controlling assumption that knowledge gain results in attitude change which results in behavioral change, has been seriously questioned in recent years. In evaluations of a variety of health education programs, disappointing results have suggested that adolescent knowledge gain has failed to be related to changes in sexual behavior (Zabin, Hirsch, Smith & Hardy, 1984; Kirby, 1985; Parcel, Luttman & Flaherty-Zonis, 1985; Dawson, 1986; Kegeles, Adler & Irwin, 1988; Flora & Thoresen, 1988; Boxer et al., 1989; and Taylor et al., 1989), or to changes in alcohol and drug use (Green & Kelley, 1980; Kim, McLeod & Palmgren, 1989; Kim, McLleod & Shantizis, 1989; and Smart, 1989). Doubts have been cast too, on the effectiveness of knowledge campaigns to impact adolescent risk for contracting AIDS (Bliss & Scott, 1989). While there is evidence to support the claim that health education does significantly increase knowledge about health practices (Kirby, 1985; Parcel et al., 1985; Boxer et al., 1989), the impact on attitudes, intentions and behavior are much less certain. For example, Green & Kelley's (1989) study of a school drug and alcohol prevention curriculum, and its impact on changing underlying attitudes, concluded that the program produced very little effect on attitudes. Kim et al. (1989) found a negative effect on health promoting attitudes in their evaluation of a drugs refusal skills program. They found that a higher proportion of students at the time of the posttest felt it would be more difficult to say "no" than at the time of the pretest. Kim and colleagues suggest that students seemed to become more conscious of the complex issues and implications involved in saying "no." Thus, healthy attitudes may not necessarily encourage healthy behavior.

The evidence of the impact of education on behavioral intentions is not very encouraging either. For example, Kegeles et al. (1988) found that "sexually active adolescents report placing high value and importance on using a contraceptive that protects against STD's [sexually

transmitted diseases] and know that condoms prevent STD's, yet the females continued not to intend to have their partners use condoms and the males' intentions to use condoms decreased [over the two year study] " (p. 461). "Currently there is little conclusive evidence to show that sex education improves adolescents' responsible sexual behavior" (Boxer et al., 1989). Health education courses may educate students about the physiology of sex but rarely impact attitudes or behavior (Flora & Thoresen, 1988; Taylor et al., 1989). Evaluations of drug abuse prevention programs have had similar results. Kim et al. (1989) report that initial impact in lowering substance abuse among adolescents in grades 5-7 diminished significantly as these students entered senior high school. Smart's (1989) study of increased exposure to alcohol and drug education also showed a failure to reduce substance use.

The limited success of health education programs in producing health-promoting behavior has led some to conclude that evaluation of health education programs should be based upon knowledge gain not on behavior change (Kirby, 1985; Parcel et al., 1985; Taylor et al., 1989). The following section of this paper explores some of the factors which may begin to explain why health education programs have not been completely successful in altering adolescent health behavior. It is suggested that success of knowledge gain curricula would be augmented by an additional focus on enactment skills.

The Enactment Problem

The paramount concern for identity management which supersedes health-promoting intentions contributes greatly to the problem of enactment. Social Psychologists argue that the drive to manage public identity is motivated by the desire to be viewed positively by others and by oneself (Weary & Arkin, 1981; Baumeister, 1982). Weary & Arkin (1981) define self-presentation as "...the process of establishing an identity through the appearance one presents to others. . . the more or less intentional control of appearances in order to guide and control the responses by others toward us" (p. 225). Jones and Pittman (1982) include overt behavior as one component of strategic impression management: "The actor uses his behavior to convey something about him or herself, regardless of what other meaning or significance the behavior may have" (p. 233). Weary and Arkin (1981) include physical appearance, overt behavior, verbal descriptions of

behavior, and verbal descriptions of reasons for behavior as strategies of impression management. The consequences of exercising strategies of impression management may result in conformity to peer group behavior (Baumeister, 1982);

> It has been argued here that self presentational concerns and motivations play a central role in determining conformity and in determining whether people yield to the influence of others or do the opposite of what others attempt to induce them to do. . . (p. 21)

This overriding concern for self-presentation becomes problematic for the adolescent attempting to enact a health-promoting behavior which conflicts with peer group expectations. Blum (1985) discusses the three options available to the adolescent; (1) reject the peer group because the behavior is too discordant with personal belief, (2) participate in the activity although it violates personal beliefs, (3) acknowledge both the desire to remain part of the peer group and the desire not to participate. Blum argues that rarely do adolescents even recognize this third alternative. The complexity involved in sending a "mixed message," that addresses multiple goals, may be too demanding for most adolescents (Blum, 1985). For these teens, compliance becomes the "membership dues" necessary to maintain peer relationships (Blum, 1985).

Chassin et al's (1987) review of existing evidence suggests that self-concept and social motives are significant determinants of adolescent's health-relevant behaviors. For example, the adoption of chewing tobacco may be viewed as a way of expressing a "jock" or "cowboy image" (Chassin et al., 1987). Chassin and colleagues also suggest that adolescents often view behaviors as short-term experimentation with particular social identities and do not see these as long-term commitments. This provides insight into why adolescents may ignore information on long-term health consequences of some health practices (e.g., smoking). There is evidence to support the strong influence of peers as the most common source of health information (Kisker, 1985; Melton, 1988; Boxer et al., 1989); influence of peers as the overwhelming factor in predicting sexual activity (Hayes, 1987); the increasing reliance on peers in decisions about drug use as adolescents get older (Bailey & Hubbard, 1990); and that the paramount concern guiding much of adolescent health behavior is social identity management (Gilchrist & Schinke, 1983; Kisker, 1985; Duryea & Okwumabua, 1985; Ross, Caudle & Taylor, 1989).

The success of health education in increasing adolescents' knowledge about health practices and in promoting generally positive values and attitudes concerning health behaviors, have been necessary but not sufficient in producing healthy behavior. A focus on altering intentions alone does not recognize the important self-presentation concerns that are a part of an adolescent's social reality in enacting health behaviors. For some adolescents, knowledge gain about health issues becomes a double-bind situation in which they know why they should behave in health promoting ways, but they don't know how to negotiate those behaviors in social situations. Some health educators (Duryea & Okwumabua, 1985) have begun to realize this lacking in current curricula and have called for a social skills component to health education. The next section of this paper critically reviews some common components of current skills curricula.

A Call for Skill Curricula

Educators and researchers have called for skills components to health curriculums in sexuality education (Gilchrist & Schinke, 1983; Boxer et al., 1989; Forrest & Silverman, 1989), drug and alcohol education (Goldstein, 1989) and as an AIDS prevention strategy (Flora & Thoresen, 1988; Melton, 1988; Ross et al., 1989). Researchers have found a correlation between communication deficits and felt social pressure to drink alcohol (Spitzberg & Cupach, 1989). And enhanced practice of communication skills between teen couples has been related to greater use of contraception (Gilchrist & Schinke, 1983). While there is recognition of the need for and efficacy of skills curriculum, the focus of current curricula is fairly narrow. In Forrest & Silverman's (1989) survey of over 4,000 health educators, sex education teachers reported that one of their three most important messages for their students was "knowing the importance of abstinence and how to resist pressures to become sexually active". Eighty-three percent reported actually providing instruction on resisting peer pressure. The three primary types of such instruction are (1) decision making sills, (2) teaching openness in peer communication and (3) teaching refusal skills as an assertiveness strategy.

Health education curriculums which teach decision making skills generally focus on health content of decisions rather than on the process of decision making (Lewis & Lewis, 1982). Some

work has suggested that focus on individual cognitive development in decision making may be a useful approach to teaching this skill (Duryea, 1986). Forrest & Silverman also reported that slightly fewer than 45 percent said that they need more factual information about abstinence and sexual decision-making while about 25 percent report having difficulty addressing the topic.

Open communication skills programs stress listening, disclosing personal thoughts, and maintaining positive attitudes. Freeman's (1989) alcohol and drug prevention curriculum focuses on "open" communication in turning peer pressure into peer support through the use of group process;

> Together they learn how to be comfortable in a group, how to accept and cooperate with others, how to be accepted without losing their individuality. And they learn to deal with alcohol/drug problems openly, honestly, and in intensely personal ways.

Goldstein (1989) describes this approach which is a part of the "skillstreaming" drug/alcohol curriculum. Students are taught skill alternatives to aggression (e.g., helping others, sharing, responding to teasing, keeping out of fights), skills for dealing with feelings (e.g., expressing affection, dealing with fear), and skills in convincing others (e.g., telling the other person your idea, asking them to consider your idea).

Refusal skills are taught as an assertiveness strategy in some curriculums. In the skillstreaming curriculum one module teaches students how to "stand up for their rights" and asserting personal decisions over group pressure (Goldstein, 1989). Freeman's (1989) curriculum emphasizes the distinction between assertiveness and aggressiveness, and teaches skills in being assertive while preserving relationships. The Flash (1986) curriculum also stresses assertiveness.

While many educators are beginning to emphasize the necessity to teach social skills to adolescents in order to produce healthier behavior, they are critical of some aspects of the current skills curriculums. First, scant attention has been paid to the possible effects of ethnic, racial or gender differences of students and how this may impact the way the materials are perceived. For example, much of the recent skills-based substance abuse curricula has been developed for white, middle-class populations (Goldstein, 1989). Second, an ethical dilemma is raised concerning

teaching social skills that may help students to fit in better with peer groups but not necessarily promote abstinence (Freeman, 1989). Third, simplistic "just say no" refusal skills training has come under fire by those who recognize how difficult this is for adolescents to do (Melton, 1988; Goldstein, 1989). Further, "numerous studies (cf. Kern, 1982; Wildman, 1986; Woolfok & Dever, 1979) show that assertive refusers are perceived as offensive and unlikable (Albert, Hecht, Miller-Rassulo & Krizek, in press, p. 2) and that a direct refusal of peer pressure is likely to lead to additional pressure (Albert et al., in press). Researchers have called for carefully planned interpersonal skills training which addresses the social complexity of "risky situations." Fourth and finally, realism in skills application is recognized as a necessary but not common component of classroom instruction. These researchers recognized that mastery of skills in the classroom must be made transferable to their real world (Flora & Thoresen, 1988; Boxer et al., 1989; Goldstein, 1989).

There are three key components of health curricula that have been most successful in effecting adolescent behavior: (1) role-play sessions in which enactment is practiced, (2) peer coaching and feedback, (3) discussion of real-life situations often generated by the students themselves (Gilchrist & Schinke, 1983; Flora & Thorensen, 1988). Flora & Thoresen's (1988) review of some curricula with these components show high success rates (as much as 40% - 70% reduction in smoking onset among junior high school students) which have been maintained up to five years. Further research is badly needed to explore the success rate of these curricula and how it varies across skill type and health topic.

Although skill curricula seem to be developing more relevant and useful components, it appears some important dimensions of the enactment problem are not being addressed. Blum's (1985) description of the three options available to the adolescent facing the enactment problem, (1) reject the peer group and the risky behavior, (2) reject ones' personal beliefs and engage in the peer activity, or (3) acknowledge both desire to belong in the peer group and desire not to participate, draw attention to the challenge of health educators to convince adolescents that the third option is a viable one. Skills training must be focused at making it possible to enact a health-promoting choice while maintaining self-presentational goals. This will entail teaching adolescents how to: (1)

manage multiple goals in an interaction, (2) how to manage relationships which endure beyond a single enactment situation (long-term peer pressure must be dealt with as well as peer pressure within a single incident), (3) managing positive self-image while not necessarily negatively defining others, and (4) alternatives to openness and assertiveness as refusal strategies. It is critical that adolescents not only learn to understand the issues of self-presentation, but that they learn communicative strategies for dealing with them. As was noted earlier, Kim et al. (1989) found a decrease in health promotive attitudes as the complex issues were made salient, but no skill mastery equipped students to effectively deal with the new complex issues.

Deetz and Stevenson (1986) refer to the process of dealing effectively with social situations as "Interactional Management;"

> Interactional systems develop in response to numerous and potentially conflicting goals. *Interactional Management* focuses on interventions in the system to break destructive cycles and make productive ones more likely. The goal is continued negotiation of both content and relational goals. . ."

Deetz and Stevenson's interactional management necessitates development of skills in managing the interaction non-verbally (e.g., self presentation and regulating participation), managing defensiveness (e.g., constructing non-defensive messages), and managing interpersonal conflict (e.g., strategies of blocking and unblocking conflict discussion). Deetz and Stevenson also include understanding of interpersonal systems as a part of interactional management. This necessitates learning to interpret what is "happening" (e.g., taken for granted knowledge, episodes and scripts and relationship roles) and diagnosis of interaction problems (e.g., mixed messages and meaning denial, undesired repetitive patterns).

Adolescents would also benefit from development of their "interactional flexibility." That is, the ability to match responses to goals and to tailor responses to the individual situation (Spitzberg & Cupach, 1989). Development of flexibility is important in transferring skills learned in the classroom to the real world. Adolescents must have a diverse repertoire of strategies in order to deal with the variety of pressures they encounter.

While openness and assertiveness provide two alternative refusal strategies, they tend to force adolescents to choose one of Blum's first two options - either reject or accept the peer group. Alternative strategies which might not force this choice include developing accounts for behavior which do not negatively define peers. Tedeschi and Reiss (1981) discuss the use of accounts as a verbal impression management strategy. In these instances individuals "explain themselves" to others. Tedeschi & Reiss have developed a typology of accounts including excuses (e.g., lack of intention, lack of volition, denial of agency) and justifications (e.g., appeal to higher authority, appeal to loyalties, appeal to humanistic values). This theme is present in an article in a 1989 issue of Current Health , a health curriculum magazine for adolescents. The article "Saying No nicely" includes a survey of teen advice on how to say "no" to peer pressure to drink alcohol. The teen advice includes a variety of useful "excuses";

* "I'd really rather not have one. I haven't been feeling well all day and the thought of beer makes me want to throw up."

* "I'm not allowed to drink. My parents are very suspicious and will check me when I get home."

Others suggested deception as a self-presentation strategy;

* "When I first ran into this situation I would take one drink and then carry it around with me all evening. Nobody ever figured out I wasn't drinking any."

These alternatives to the assertive strategy of a direct "No" or to "open" discussion of feelings, widen adolescents' self-presentation repertoire with strategies that do not require threatening the identity of themselves or of their peers. Because these strategies neither require adolescents to reveal personal feelings nor to assert values upon their peer group they may be more likely to be used by adolescents.

The call for skills curricula in health education, to augment the success of knowledge gain curricula, has brought a needed recognition to the problem of enactment. Providing health information to adolescents may have an impact on intention to act in health-promoting ways but does not prepare students to carry through with those intentions. Adolescents must be helped over the gap between knowledge, intention and behavior. The successful components of current skills curriculums, role-plays, peer coaching and realism should continue to be developed to help bridge

this gap. In addition, consideration should be given to interpersonal interaction management as a health curriculum component. Equipping adolescents with alternatives to avoid choosing between their own values and their peer group should be paramount. Adolescents need to learn how to enact their health-promoting intentions without rejecting their peer group. The proscriptions given here can be effective only insofar as we are able to provide useful and relevant curriculums for adolescents which apply in the context of enacting health-promotive behaviors. The following section of this paper suggests a research agenda for the study of the enactment problem that would inform our curriculum development.

Research Agenda

There is a need for a theory based approach to the development of a skills curricula (Flora & Thoresen, 1988; Millstein, 1989). Research is needed to provide a basis of a theory of health behavior enactment. There are at least three general questions that this research must address: (1) How do adolescents deal with the enactment problem, (2) What factors contribute to their strategy choices, and (3) How communicatively competent are adolescents.

First, it is necessary to discover how adolescents choose to come to grips with the conflict between health-promotive intentions and peer influence. The current evidence would suggest that adolescents tend to either conform to peer expectations or reject the peer group. It is important to understand how adolescents come to view these limited options, and for those exercise other alternatives, how they come to do so. It is also important to distinguish between adolescent's familiarity with alternatives and their actual enactment of those alternative strategies. To know there are options, but never to exercise those options, may indicate a felt lack of competence. It would also be useful to know how successful adolescents feel in their self-presentations during health behavior enactment. This would give insight into the choices they make and whether they perceive themselves as "giving in" to peer pressure. It may be that attempts to empower adolescents with alternative strategies may be met with a disinterest on their part.

Second, it will be important, in developing effective curricula, to understand why adolescents make the enactment choices that they do. There is evidence to suggest that choices of persuasive strategies is related to development of cognitive abilities (cf. Delia, Kline & Burleson,

1979). There is also need to investigate the moderating variables in individual's avoidance of some communicative strategies (e.g., assertiveness). There is room to question the assumption that assertiveness is a skill that can be learned (Kelly, 1984). There is also evidence to suggest that a highly predictive variable of communicative strategy use is the context of the interaction. Miller, Boster, Roloff & Seibold (1982) found that differences in compliance gaining strategies was due in large part to the nature of the relationship between the individuals (e.g., long-term relationship scenarios produced different selection of strategies than did short-term relationship scenarios). It is likely that the context of health behavior enactment (e.g., social situations like parties, intimate romantic situations), as well as specific health topics (e.g., sexuality, drugs, smoking), will limit the sorts of communicative strategies that adolescents will be willing to use. It will be important to know how adolescents view the socially appropriateness of various strategies in designing skills curricula.

Third, it will be useful to know how communicatively competent adolescents are in general. While research had been devoted to the study of adult communicative competence and children's development of communicative competence, a great deal more evidence needs to be gathered concerning the competence of adolescent communication. The particularly strong self-presentational needs during this stage of maturation certainly must shape our definition of what it means to communicate competently as an adolescent to ones peers. Such a grounded view of competence should be developed and incorporated into a theory of health behavior enactment.

Conclusion

The challenge of health education is to produce health-promoting behavior in adolescents. While efforts to increase knowledge about health and to impact intentions to choose healthy behaviors have been somewhat successful, there is a need to address adolescents' skill deficit in enacting their health choices. The focus on altering intentions, although somewhat successful in its own right, does not recognize the need for equipping adolescents to enact their health choices. The overwhelming concern for self-presentation creates a conflict for adolescents who feel they must choose between personal values and peer affiliation. For these adolescents, conformity to peer

behavior becomes a reasonable price for membership. The challenge for health educators and researchers is to help adolescents bridge the gap between intention and enactment. Skills training must be focused at making it possible to enact a health-promoting choice while maintaining self-presentational goals and while avoiding negatively defining the peer group. Skills curricula need to address the complexity of interpersonal interactions and provide skills which are transferable to real world situations. Such an approach will necessitate the strengthening of an adolescent's strategic repertoire beyond the traditional "openness" and assertiveness strategies. A necessary step in developing effective health-behavior enactment curricula, is the development of a communication based theory of the enactment problem. Until we begin to understand how adolescents deal with peer influence in enacting their health choices, we will not be able to bridge the gap between intention and enactment.

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